ABSTRACTS

A Study of the Conditions that Require the Removal of the Child from the Breast.—CHAS. B. REED, M. D. Surgery, Gynecology and Obstetrics, May, 1908.

After an exhaustive study of the literature of the conditions that require the removal of the child from the breast, Reed finds sufficient evidence to discredit many popular beliefs of the present day. Only within the past few years have clinical data been prepared with sufficiently scientific methods to enable the investigator to draw accurate conclusions.

Regarding the effect of various drugs on the child, it has been found that alcohol, opium, chloroform, ether, thyroid extract and lead pass over from the mother to the nursling in sufficient amount to cause distinct functional and nutritional disturbances. This is especially true of alcohol and opium. Zinc has practically no effect. All the other drugs investigated, namely, atropine, arsenic, antipyrine, acetic acid, bismuth, potassium bromide, balsam of copaiba, castor oil, copper, chloral, iodine and its compounds, mercury, phenacetin, quinine, salicylic acid and senna, pass over in such small quantities as to affect the child but rarely. The large number of nursing mothers taking medicine combined with the rarity of injurious effects on the child seems to support this contention. From this statement of fact, it is evident that treatment of the child through the medium of maternal milk is useless.

In the second portion of the paper, the author discusses certain anatomic and physiologic conditions that prevent nursing and concludes with a study of the influence of the infectious diseases. Attention is called to inverted nipples, facial paralysis, due to forcep delivery, and hare lip in which condition sucking is impossible because of a labio-palatine fissure. The condition commonly known as tongue tie does not interfere with nursing as, during this act, the tongue is pressed firmly against the lower maxilla. The continual grinding and rubbing of the nipple may produce maceration of its tissues. Pyogenic infection is favored. Injuries, such as cracks and fissures, are dependent to a large extent upon the form of the nipple and the strength of the child. Platzner estimates that nearly one-half of all nipples show lesions of some kind. If these disorders are not relieved within a short time, the child should be taken from the breast, lest it nurse purulent material with the milk. The ingestion of pus by the child is productive of serious gastro-intestinal disturbances, abscesses, toxæmia and finally death. The return of the menstrual function has a distinct influence upon the quality of the milk, but unless the child ceases to gain in weight or suffers from gastric troubles, lactation should be continued.

The advent of a new pregnancy does not always call for artificial feeding. Budin has shown that milk at four and a half months of pregnancy shows no abnormality. If the mother is able to stand the double burden of pregnancy and lactation without injury to herself or babe, lactation may be continued for a time.

Albuminuria persisting after delivery is not incompatible with nursing as far as the child is concerned, but a long continued albuminuria exercises too great a strain upon the mother, and for this reason the child should be removed.

The passage of pyogenic cocci from the blood into the milk is possible and may occur as early as twenty-four hours after delivery. Even the milk of sound mothers has been shown to contain various pyogenic bacteria.

The infective and contagious diseases, such as typhoid, all the eruptive fevers, erysipelas, acute pulmonary affections and acute articular rheumatism, are direct and positive contra-indications to nursing of child. Primary tuber-

culosis of the breast always prohibits nursing, as the tubercle bacillus is able to pass over in the milk.

As a general rule, nephritis, serious and obstinate erosions and fissures of the nipples, malignant disease of the breast, abscess, tuberculosis and syphilis, osteomalacia and all puerperal infections that are not mild and transitory in character, demand the absolute separation of the mother and child.

The Death of the Mature Fetus in Labor—Herbert M. Stowe, Professor of Surgery, Gynecology and Obstetrics, April, 1908.

The gradual diminution of fetal mortality during delivery is due to a better knowledge of the causes of stillbirths and more accurate observations taken during the second stage of labor. During the past seven years, 15,542 stillbirths have been reported to the Chicago Health Department and it is estimated that this number represents but thirty per cent of the total number. While statistics are often inaccurate, it is probable that one full term, healthy fetus dies during labor in every twenty five deliveries.

Much of this mortality is due to the failure to observe the fetal heart tones carefully during labor when the child dies without the knowledge of the attending physician, to the too early delivery by the forceps before the maternal parts are prepared for extraction and the injuries received as a result of deformed pelves. Accurate measurements and observations during or before labor prepares the attendant to meet the various complications successfully and to save the child's life.

Of the series of 190 cases of stillbirths reported, over one half of the pelves were deformed and but in 19 was the delivery spontaneous, showing the great importance of pelvic measurements in this class of difficult labors. One third of the cases were complicated by malpresentations, the great majority being caused by deformed pelves.

Other conditions that call for more careful observations during labor are precipitate and prolonged deliveries, the size of the child, prolapse of the funis, the early escape of the amniotic fluid, premature detachment of the normally implanted placenta, placenta previa and rupture of the uterus.

The most certain sign of threatening intra-uterine asphyxia is the increase or decrease in rapidity of the fetal heart tones. The normal range is from 120 and 160 beats per minute. Absence of heart tones is not conclusive evidence that the child is dead. The count is always to be taken during the interval between pains and after the heart has had time to readjust itself after the disturbance of the uterine contraction has passed away. The rate is usually slowed at first because of irritation of the vagus by venous blood. Later, the rate is increased as paralysis of the heart occurs and extraction should be accomplished before the danger point is reached.

The passage of fresh or black meconium is a sign of importance during any period of labor, excluding breech deliveries and usually calls for immediate delivery.

Vagitus uterinus or the effort of the child to breathe in utero indicates immediate delivery but unless the conditions are present or if a difficult operation is necessary, the child is lost. Excessive fetal motions should put the attendant on his guard but unless corroborated by other evidence, extraction is not to be attempted.

Method for the Routine Examination of Diastase Preparations—W. A. Johnson, Journal American Chemical Society, May, 1908.

Among medicinal agents the starch digestants or diastases have always possessed considerable importance, theoretically at least. The practical value of many of these preparations is a matter of doubt, however, as some of them are weak to begin with, and most of them become weak or even inert